COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1934-03
Bill No.: Perfected HCS for HB 781
Subject: Medicaid; Social Services Department
Type: Original
Date: April 30, 2013

Bill Summary: This proposal changes the laws regarding MO HealthNet-funded home- and community-based care.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
General Revenue	(Greater than $4,160,247)	(Greater than $5,700,516)	(Greater than $5,890,382)
Total Estimated Net Effect on General Revenue Fund	**(Greater than $4,160,247)**	**(Greater than $5,700,516)**	**(Greater than $5,890,382)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 14 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
Federal*	$0	$0	$0
Unemployment Compensation Trust	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on All Federal Funds	**(Unknown)**	**(Unknown)**	**(Unknown)**

*** Income and expenditures net to $0.**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
General Revenue	18.5	18.5	18.5
Federal	18.5	18.5	18.5
Total Estimated Net Effect on FTE	**37**	**37**	**37**

☒ Estimated Total Net Effect on All funds expected to exceed $100,000 savings or (cost).

☒ Estimated Net Effect on General Revenue Fund expected to exceed $100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Due to time constraints, **Oversight** is relying on agency responses from the previous version of this proposal.

In response to the previous version of this proposal, officials from the **Department of Health and Senior Services (DHSS)** provided the following assumptions:

§ 208.895.1.(3) - Notify referring entity:

This subparagraph requires the department to notify the referring entity within five business days of receipt of the referral if additional information is required. Approximately 18,000 referrals annually would require this initial review.

For FY 13 to date, approximately 70 percent of referrals are completed within 15 days. Those not completed within 15 days usually have extenuating circumstances such as client health status changes, delays in receipt of requested additional information, or difficulty in scheduling assessments in a client's schedule. For the purposes of this fiscal estimate, DHSS assumes that those assessments would be completed by Home and Community Based Service (HCBS) providers.

The department would staff five regional teams of eight FTE each to perform the initial five-day review of referrals for completeness and to process provider-completed assessments and care plan recommendations for a total of 40 FTE.

- Six Adult Protective & Community Worker (APCW) IIs dedicated to conducting the initial review of referral requests; follow-up with providers, medical professionals and the applicant to ensure all necessary information is collected; and processing of provider-completed assessments. Each initial review would require an average of two and one-half hours to complete. Each provider-completed assessment would require an average of four and one-half hours to complete. The DOHSS receives approximately 18,000 referrals per year. (18,000 X 2.5 = 45,000 hours/2,080 = 21.63 FTE for initial referral review; 18,000 X 30 percent = 5,400 X 4.5 hours = 24,300/2,080 = 11.68 FTE; 21.63 + 11.68 = 33.31 rounded to 30/5 regions = 6 FTE per region.)
- One Adult Protective & Community Supervisor (APCS) to provide oversight and accountability for the performance of APCWs including review, evaluation, and guidance. The APCS would also prioritize referral requests based on client risk status. (1 X 5 regions = 5 FTE)
- One Senior Office Support Assistants-Keyboarding (SOSA-K) to provide clerical support services for APCWs and APCSs including scheduling, correspondence, data entry, filing, and other routine clerical duties. (1 X 5 regions = 5 FTE).

ASSUMPTION (continued)

§ 208.895.2 - Provider may conduct initial assessment:

Section 208.895.2. allows a provider to conduct the initial assessment and develop the plan of care if an initial referral is not processed within fifteen business days of receipt. If the DHSS fails to act within five days of receipt of the assessment and plan of care from the provider, the care plan becomes effective. This would be a violation of the rules set by the Centers for Medicare and Medicaid Services (CMS), for Medicaid State Plan and Waiver services. This action could cause a disallowance of Federal Medicaid funds because the care plan is not approved by the state as required in the Medicaid State Plan. This could result in an unknown loss of Federal funding, which, if services continued at the same level, would require additional General Revenue.

DHSS assumes that any assessments completed by HCBS providers would be performed at no cost to the department.

§ 208.895.6 - Training for providers and staff:

DHSS would require two Aging Program Specialist (APS) IIs to develop training for providers and staff, develop service standards regarding assessments, file rules and regulations, field questions from staff regarding policy issues, answer inquiries from the CMS, and develop quality review methods.

DHSS would require one Training Technician II to complete initial training of new assessors and provide periodic training thereafter for updates of the web tool and the assessment tool and to ensure assessments are conducted according to state and federal statutes and regulations, Medicaid rules, and DHSS policies.

§ 208.895.7 - Automated electronic assessment care plan tool:

An unknown ongoing cost would be associated with alterations to the web tool to allow assessors to enter data regarding assessments and care plans, and develop an automated electronic assessment care plan tool and make recommendations to the General Assembly by January 1, 2014, for the implementation of the tool.

If the recommendations are accepted, DHSS assumes the development and implementation of the tool would move forward in FY 15 at an unknown cost, but expected to be greater than $100,000, because it would involve programming changes to the web tool and MO HealthNet's Medicaid Management Information System (MMIS).

HWC:LR:OD

ASSUMPTION (continued)

§ 208.895.8 - Report preparation:

DHSS would also require two Management Analysis Specialist (MAS) IIs to review data regarding assessments completed, determine statistical norms, design reports and reporting methods, calculate valid sample sizes, conduct random sampling of services, participants, and providers, identify outliers in data, and analyze the impact of the assessment methods on the cost of services, amount of services authorized, and participant satisfaction. These elements would be included in the report required at the end of the first year of operation. For the purposes of this fiscal note, DHSS assumes this reporting will be ongoing for the purposes of quality review, process improvement, and maximization of funding for HCBS.

One Senior Office Support Assistant-Keyboarding (SOSA-K) would provide clerical support for the APS IIs and MAS IIs including scheduling, correspondence, data entry, filing, and other routine clerical duties.

All costs associated with this proposal would be paid at 50 percent General Revenue and 50 percent Federal.

DHSS assumes the FY 14 costs to the General Revenue (GR) fund for this proposal to be Unknown, greater than $1,348,467; FY 15 GR costs are Unknown, greater than $1,489,792; and FY 16 GR costs are Unknown, greater than $1,504,191. In addition, the DHHS assumes an unknown cost to Federal funds each year of an amount equal to the costs to the GR fund.

Oversight notes that in response to similar legislation from the prior year (HCS SS SB 854/LR# 5977-04) for section 208.895.1, DHSS assumed 20 Adult Protective and Community Worker IIs would be needed to assure compliance with the provisions of the proposal and process 20,000 referrals (4 workers per region rather than the 6 requested in the current response, plus the associated supervisor and office support assistant). Therefore, Oversight assumes the DHSS would not need 10 additional Adult Protective and Community Worker IIs to review 2,000 fewer referrals. However, if it is later determined additional staff are needed, DHSS may go through the appropriations process to request additional funding/resources.

Oversight assumes the DHSS will process completed referrals containing care plans within the provisions of the proposal. Oversight also assumes the disallowance of services by CMS to be speculative and is not presenting these potential costs in the fiscal note as it is assumed DHSS will perform the duties outlined in the proposal in a manner to minimize these potential costs.

ASSUMPTION (continued)

In response to the previous version of this proposal, officials from the **Department of Social Services (DSS) - MO HealthNet Division (MHD)** stated this proposal requires the Department of Health and Senior Services (DHSS) to process referrals for home and community based services within 15 days. If additional information is needed, DHSS must notify the referring entity within 5 business days. If DHSS has not scheduled the assessment within 10 business days of the referral, they must notify the referring entity. If DHSS does not process the referral within 15 days of receipt by the department, the provider has the option of completing an assessment and care plan recommendation. Once received by DHSS, the care plan and assessment must be approved or modified within 5 business days. If such approval, modification or denial by DHSS doesn't occur within 5 business days, the care plan of the provider shall become effective.

If a referral is not processed within 15 days, the care plan recommendations shall become effective. There is a possibility that more hours than medically necessary may be included in the referral. Excess hours assessed by the provider's assessor or physician from what is medically necessary and covered under the service parameters would not be eligible for Medicaid reimbursement, leading to potential disallowances. If DHSS authorizes the excessive hours as required by this legislation, but a Office of Inspector General (OIG) audit determines the number of hours are not medically necessary, the state would be required to reimburse the federal government for the disallowed funds. This cost is unknown.

This proposal would require one full-time FTE for MHD at the Program Development Specialist level to conduct increased provider monitoring and oversight to ensure that providers are completing the assessments and the development of care plans appropriately in order to avoid federal sanctions.

MHD assumes the cost for this FTE as follows:

FY 14 (10 months): $60,552 ($30,277 GR; $30,275 Federal);
FY 15: $63,649 ($31,824 GR; $31,825 Federal); and
FY 16: $64,321 ($32,160 GR; 32,161 Federal).

Oversight assumes MHD's monitoring of plans of care for approval within the 15 day deadline will help prevent medically unnecessary services from being provided because a care plan was not approved in a timely manner. Therefore, Oversight is presenting MHD's costs for one FTE.

§ 660.351 - Unemployment compensation exemptions:

In response to the previous version of this proposal, officials from the **Department of Labor and Industrial Relations (DOL)** stated this proposal relieves charges for unemployment benefits if certain conditions are met. Based on information provided by the Department of

ASSUMPTION (continued)

Health and Senior Services, the DOL assumes this proposal would apply to home health care providers, nursing and residential care facilities, and services for the elderly and persons with disabilities.

The DOL assumes this proposal would apply to contributory employers and not apply to reimbursable employers. All liable contributory employers must pay state unemployment taxes. These tax rates are based on employer's prior experience in the unemployment system. All else being equal, the more benefits paid to an employer's former employees, the higher the employer's tax rate. As a result of this proposal, if the worker is terminated due to the circumstances outlined in the proposal, the employer's tax rate would not be affected by the benefits paid to this former employee. When benefit charges are not applied to a specific employer, they are charged to a pool.

In SFY 12, former employees of contributing employers affected by this legislation as outlined in the legislation received unemployment benefits totaling approximately $13.0 million. Had all of these benefits been non-charged due to circumstances outlined in the proposal, this proposal would have resulted in an additional $13.0 million in pool charges in SFY 12. The DOL cannot estimate the effect these pool charges would have on the unemployment trust fund.

Some employers (governmental entities, 501(c)(3) organizations and federally recognized Indian tribes) are eligible to choose to opt out of the unemployment insurance experience rating system and become reimbursable employers. All liable reimbursable employers reimburse the state's unemployment trust fund for the benefits paid to their former employees. If a worker is terminated due to the circumstances outlined in this proposal, the DOL assumes a reimbursable employer will still be required to reimburse the state's unemployment trust fund for the benefits paid to the former employee.

An ancillary effect of this legislation would be that the responsibility for paying the pool charges created by this law change would be shifted from contributory employers in the affected industry classifications to all contributory employers because these increased pool charges may result in secondary tax rate adjustments being in effect longer than if this proposal were not enacted. Secondary tax rate adjustments are activated when the trust fund balance either exceeds or falls below certain levels as prescribed by Sections 288.036, 288.121 and 288.122, RSMo.

In response to the previous version of this proposal, officials from the **Department of Mental Health (DMH)** assumed the Department of Health and Senior Services will process referrals made within the 15 and 5 business day requirement. The changes in this proposed legislation relating to the disqualification list have no fiscal impact. Therefore, this proposal creates no direct requirements that would result in a fiscal impact to the DMH.

HWC:LR:OD

ASSUMPTION (continued)

In response to the previous version of this proposal, officials from the **Office of Secretary of State (SOS)** stated many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The Secretary of

State's office is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. The fiscal impact for this fiscal note to the SOS for Administrative Rules is less than $2,500. The SOS recognizes this is a small amount and does not expect that additional funding would be required to meet these costs. However, it is also recognized that many such bills may be passed by the General Assembly in a given year and that collectively the costs may be in excess of what the office can sustain within its core budget. Therefore, the SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

In response to the previous version of this proposal, officials from the **Office of State Courts Administrator** and the **Department of Revenue** each assumed the proposal would not fiscally impact their respective agencies.

In response to the previous version of this proposal, officials from the **Joint Committee on Administrative Rules (JCAR)** stated the legislation is not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

House Amendment #1:

Due to time constraints, **Oversight** is using agency responses from HB 598 for this amendment.

Officials from the **Department of Mental Health** and the **Department of Health and Senior Services** each assumed the proposal would not fiscally impact their respective agencies.

Section 208.960

Officials from the **Department of Social Services-MO HealthNet Division (MHD)** assumed the legislation requires chiropractors to be reimbursed under MO HealthNet for providing services currently covered by MO HealthNet and within the scope of chiropractic practice. This legislation will increase utilization of currently paid procedure codes.

ASSUMPTION (continued)

Studies that determined the utilization of chiropractic care in the general population were reviewed to determine the potential number of MO HealthNet participants who might receive chiropractic care if this legislation passed. It is assumed that utilization in the MO HealthNet population will be similar to the general population. The National Institutes of Health (May, 2004) found that 7.5% of adults used chiropractic care within the previous 12 months. The Southern Medical Journal (April, 2000) reported that 8.7% of adults used chiropractic care within the previous 12 months. The National Institutes of Health (2007) found that 3% of children had used chiropractic services in the previous 12 months. MHD chose to use 8% for adults and 3% for children as the estimate of the percentage of the MO HealthNet population that will use chiropractic services.

The number of MHD participants age 19 and above in FY12 was 406,688. It is estimated that 32,535 (406,688 x 8%) participants will utilize chiropractic care. There were 547,049 children less than 19 years of age. It is estimated that 16,411 (547,049 x 3%) will utilize chiropractic care. Therefore, a total of 48,946 participants are estimated to use chiropractic care.

It is assumed under this legislation chiropractors would, at a minimum, bill for manipulative treatment and certain physical therapies. The cost developed below is for manipulative treatment only and it is assumed additional unknown cost would be incurred for physical therapies. Procedure codes 98925, 98926, 98927, 98928, and 98929 are codes which are currently utilized for osteopathic manipulative treatment. An average rate for these procedure codes is $28.93.

The number of medically necessary chiropractic visits that will be prior authorized for each participant is not known. For the purpose of the fiscal note it is assumed that a series of 8 visits per year will be authorized. It is possible that some participants will receive more visits and some less. The annual cost for one person will be $231 (8 visits x $28.93 = $231 rounded).

It is assumed there will be only a 10 month cost in FY14. Medical inflation of 3.9% was applied to FY15 and FY16.

FY14 (10 months) Total: Unknown > $9,440,052 (Unknown > $3,065,382 GR; Unknown > $6,374,670 Federal);
FY15 Total: Unknown > $11,769,857 (Unknown > $4,488,435 GR; Unknown > $7,281,422 Federal); and
FY16 Total: Unknown > $12,228,881 (Unknown > $4,663,484 GR; Unknown > $7,565,397 Federal).

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
GENERAL REVENUE FUND			
Costs - DHSS (§ 208.895)			
Personal service costs	($502,675)	($609,242)	($615,335)
Fringe benefits	($255,082)	($309,160)	($312,252)
Equipment and expense	(Greater than $306,831)	(Greater than $261,855)	(Greater than $267,151)
Total Costs - DHSS	(Greater than $1,064,588)	(Greater than $1,180,257)	(Greater than $1,194,738)
FTE Change - DHSS	18 FTE	18 FTE	18 FTE
Costs - DSS- MHD (§ 208.895)			
Personal service	($16,450)	($19,937)	($20,136)
Fringe benefits	($8,348)	($10,117)	($10,218)
Equipment and expense	($5,479)	($1,770)	($1,806)
Total Cost - DSS-MHD	($30,277)	($31,824)	($32,160)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Costs - DSS-MHD (§208.960)			
Chiropractic benefit expenditures	(Unknown, greater than $3,065,382)	(Unknown, greater than $4,488,435)	(Unknown, greater than $4,663,484)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Greater than $4,160,247)**	**(Greater than $5,700,516)**	**(Greater than $5,890,382)**
Estimated Net FTE Change on the General Revenue Fund	18.5 FTE	18.5 FTE	18.5 FTE
FEDERAL FUNDS			
Income - DHSS			
Program reimbursement (§ 208.895)	Greater than $1,064,588	Greater than $1,180,257	Greater than $1,194,738

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
FEDERAL FUNDS (continued)			
Income - DSS-MHD			
Program reimbursement (§ 208.895)	$30,277	$31,824	$32,160
Program reimbursements (§208.960)	Unknown, greater than $6,374,670	Unknown, greater than $7,281,422	Unknown, greater than $7,565,397
Total Income - DHSS & DSS	Greater than $7,469,535	Greater than $8,493,503	Greater than $8,792,295
Costs - DHSS (§ 208.895)			
Personal service costs	($502,675)	($609,242)	($615,335)
Fringe benefits	($255,082)	($309,160)	($312,252)
Equipment and expense	(Greater than $306,831)	(Greater than $261,855)	(Greater than $267,151)
Total Costs - DHSS	(Greater than $1,064,588)	(Greater than $1,180,257)	(Greater than $1,194,738)
FTE Change - DHSS	18 FTE	18 FTE	18 FTE
Costs - DSS-MHD (§ 208.895)			
Personal service	($16,450)	($19,938)	($20,138)
Fringe benefits	($8,347)	($10,118)	($10,219)
Equipment and expense	($5,478)	($1,769)	($1,804)
Total Cost - DSS-MHD	($30,275)	($31,825)	($32,161)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Costs - DSS-MHD			
Program expenditures (§208.960)	(Unknown, greater than $6,374,670)	(Unknown, greater than $7,281,422)	(Unknown, greater than $7,565,397)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	18.5 FTE	18.5 FTE	18.5 FTE

HWC:LR:OD

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
UNEMPLOYMENT COMPENSATION TRUST FUND			
Loss - UC Trust Fund			
Loss of federal funds (§660.315)	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON THE UNEMPLOYMENT COMPENSATION TRUST FUND	**(Unknown)**	**(Unknown)**	**(Unknown)**

FISCAL IMPACT - Local Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

§208.895 - The proposal could impact small businesses that conduct care assessments as well as result in additional costs for assessments, reassessments, and care plan development as well as requirements needed to gain access to the CyberAccess WebTool.

§208.960 - This proposal would directly have a positive impact on small business chiropractic providers that choose to enroll in the MO HealthNet Program and provide services to Medicaid recipients.

FISCAL DESCRIPTION

§208.895 - Currently, the Department of Health and Senior Services can carry out certain requirements when a MO HealthNet-funded home- and community-based care referral with a nurse assessment or physician's order is received. This proposal requires the department to carry out those requirements when a referral is received.

The Department of Health and Senior Services is required to inform the applicant of the full range of available MO HealthNet home- and community-based services, the choice of provider in the applicant's area, and the option to choose more than one provider to deliver or facilitate the services the applicant is qualified to receive.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

If a properly completed referral for MO HealthNet-funded home- and community-based care containing a nurse assessment or physician's order for a care plan is not processed within 15 days of receipt by the department, the care plan recommendation by the nurse or physician will become effective thereafter.

The Department of Health and Senior Services is to develop an automated electronic assessment care plan tool to be used by providers and provide a report at the end of the first year to the appropriation committee for health, mental health and social services on how well the department is doing on meeting the fifteen day requirement, the process the department used to approve assessors, and other information as requited by the proposal.

§208.960 - This proposal requires the MO HealthNet Division within the Department of Social Services to reimburse licensed chiropractors for specific services. These services include examinations, diagnoses, adjustments, manipulations and treatments in both inpatient and outpatient settings. If a chiropractor is specially certified by the Missouri Board of Chiropractic Examiners in the Division of Professional Registration within the Department of Insurance, Financial Institutions and Professional Registration covered services may also include meridian therapy, acupressure, or acupuncture.

This legislation is not federally mandated and would not duplicate any other program.

SOURCES OF INFORMATION

Office of State Courts Administrator
Department of Mental Health
Department of Health and Senior Services
Department of Labor and Industrial Relations
Department of Revenue
Department of Social Services
Joint Committee on Administrative Rules
Office of Secretary of State

HWC:LR:OD

Ross Strope
Acting Director
April 30, 2013

HWC:LR:OD